

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

PAULINE W. ALDRICH,

Plaintiff,

v.

MICHAEL J. ASTRUE, Commissioner of
Social Security Administration,

Defendant.

CASE NO. 10-05344 BHS-JRC

REPORT AND RECOMMENDATION

Noted for March 4, 2011

This matter has been referred to Magistrate Judge J. Richard Creatura pursuant to 28 U.S.C. § 636(b)(1) and Local Magistrate Judge Rule MJR 4(a)(4); and, as authorized by Mathews, Secretary of H.E.W. v. Weber, 423 U.S. 261, 271-72 (1976). This matter has been fully briefed. (See ECF Nos. 12, 16, 17.)

At 5'1", and weighing between 335 and 400 pounds, plaintiff has long found it difficult to function. She suffers from a variety of related medical conditions, including fibromyalgia, chronic pain syndrome, degenerative disc disease, and sleep apnea. As a result of all of these conditions, she finds it difficult to perform even simple tasks such as sitting more than 20 minutes, walking with a 4-wheel-walker for more than 200 feet, or even lifting more than a small carton of milk.

1 Despite repeated suggestions by her health care providers to improve her diet and
2 increase her activity, plaintiff has been unable to control her obesity. This undoubtedly has
3 resulted in aggravation of her other related conditions, as well.

4 The Administration has issued rulings regarding how to evaluate cases such as this, and
5 the ALJ in this instance has ignored those rulings and instead stated that plaintiff's failure to
6 lose weight "suggests that her symptoms are not as severe as she alleges," concluding that she is
7 capable of sedentary work.

8 This is at odds with the opinions of her treating and examining medical health care
9 providers, who consistently state that she is not employable.

10 Although this is the second time this matter is before the court and this court is
11 recommending that the ALJ's decision be reversed, again, there are a number of questions that
12 remain regarding whether an award of benefits should be made in this case. Therefore, this court
13 recommends that the case be remanded for further proceedings consistent with this decision.
14

15 BACKGROUND

16 Plaintiff Pauline Aldrich was born in 1960. She completed her high school education and
17 two years of college, but received no degree (Tr. 636). She has worked in several capacities,
18 including receptionist, raising and training horses, refuse hauler, and private health care provider
19 (*id.*). Her medical problems and physical impairments appeared to have begun in 1993 following
20 an injury to her mid-lower back when she slipped and fell on a wet floor (*id.*). She has not
21 worked since May of 2000 (Tr. 137).
22

23 The medical evidence submitted demonstrates that plaintiff suffers from, among other
24 things, morbid obesity, fibromyalgia, degenerative disk changes of the cervical and lumbar spine,
25 chronic pain, and sleep apnea (Tr. 629). She is 5'1" and her weight fluctuates between 335 and
26

1 400 pounds (see, e.g., Tr. 553, 580, 689, 683, 681). She has a body mass index (“BMI”) over 60
2 (Tr. 391). A person with a BMI of 40 is the highest Level III obesity, which is considered
3 “extreme.” SSR 02-1p, 67 FR 57859, 2002 WL 31026506. Level III obesity represent “the
4 greatest risk for developing obesity-related impairments.” Id. Plaintiff’s BMI is 20 points higher
5 than this “extreme” level.
6

7 There is contradictory evidence in the record regarding the effect of these conditions on
8 Ms. Aldrich’s daily activities. At the hearing, Ms. Aldrich testified that she was unable to work
9 because of these conditions and that the maximum time that she is able to sit is 20 minutes (Tr.
10 631). She claims that she can only walk with a 4-wheel walker no more than 20 to 100 feet (id.).
11 She reports that she feels like she has been run over by a Mac truck (id.). The pain is so great
12 that she wakes up in tears and is exhausted all day. Furthermore, she has problems with her
13 hands and fingers that tighten up and won’t move. She cannot stand long enough to do
14 housework and has not done any yard work or gardening. She reports that she is in “excruciating
15 pain” (Tr. 632).
16

17 These claims are supported by medical evidence. Treatment records from plaintiff’s long-
18 term health care providers, Jamestown Health Clinic, note “decreased grip strength both
19 hands”(Tr. 737), “significant disability from pain” (Tr. 736), “‘excruciating pain’ when she
20 moves around” (Tr. 735), “she takes ‘four pain med’ just to take a shower” (Tr. 735), and
21 “[patient] unable to do household chores etc” (Tr. 731). When asked about daily activities,
22 plaintiff reported “‘I can make it to the bathroom now’; [however], [patient] still unable to do
23 household chores etc.” (Tr. 727).
24

25 On the other hand, there is also some evidence in the record that she has a higher degree
26 of functionality. Donna J. West, ARNP noted that the prescribed narcotics worked well in

1 controlling her pain and that she was “taking short walks daily,” “increasing her distance and
2 endurance, slowly improving” . . . [as well as making] “plans to start gardening w/in the next
3 month.” (Tr. 708.) On successive visits, Ms. Aldrich advised Ms. West that she “has been more
4 mobile since starting the long-acting pain medication” (Tr. 702), “working outside doing some
5 light gardening” (Tr. 701), and generally more active “in the spring and summer months because
6 of gardening.” This was consistent with neurological evaluations, which showed that she had
7 “good range of motion in all directions, normal muscle tone and bulk, 5/5 muscle strength in all
8 major muscle groups and no abnormal reflexes” (Tr. 630). Peter Nora, M.D. states that plaintiff
9 “has good balance, strength and does not have abnormal reflexes.” (Tr. 630.)
10

11 What is quite apparent is that any functionality plaintiff does have is largely the result of
12 a considerable regimen of prescription drugs. Plaintiff has been prescribed, among other things,
13 Oxycontin (Tr. 666, 707, 725), Oxycodone (Tr. 735, 739, 741, 742), Roxicet (Tr. 738, 741),
14 Methadone (Tr. 729, 732), and MS Contin (Tr. 724, 726, 727, 728). Although her health care
15 providers generally state that she is compliant with her dosing schedule (Tr. 708, 715, 723, 725,
16 727), there is at least one notation that plaintiff has taken more than the prescribed amounts of
17 narcotics. (Tr. 733). Many of her visits to the health clinic were for the purpose of renewing her
18 considerable prescriptions. (See, e.g., Tr. 689, 692, 696, 706, 733, 739, 741.) On a number of
19 occasions, plaintiff was advised to lose weight, increase her physical activity and stop smoking,
20 but she has demonstrated no ability to do any of these things on a consistent basis. (See, e.g., Tr.
21 545, 548, 678, 680, 682, 689, 692, 694, 695, 708, 722, 736, 737.) She is a candidate for bariatric
22 or lap band surgery, but has been unable to receive funding for this surgery, as the waiting list is
23 very long. (See, e.g., Tr. 554, 737, 741, 743, 744.)
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25
26

1 Significantly, every one of her medical providers who has ventured an opinion on the
2 subject has reported that Ms. Aldrich is incapable of performing work. Kari D. Olsen, M.D., of
3 Jamestown Family Health Clinic, who has been plaintiff's long-term treating physician, reported
4 to the Department of Social and Health Services that Ms. Aldrich was "Severely Limited/No
5 Work" (Tr. 506). Larri Ann Bond M.D., who on referral evaluated plaintiff for chronic pain
6 observed that plaintiff was "unable to seek active employment due to significant disability from
7 pain." (Tr. 736). Donna West, ARNP, with Jamestown Family Health Clinic, and who has been
8 working with plaintiff on a pain management plan for some time concluded on November 27,
9 2009, that "[a]t this time, Pauline is not employable because of the aforementioned disabilities.
10 We are working on a pain management plan that will relieve Pauline's pain and improve her
11 functionality. However, even with an increase in functionality, I do not anticipate any change in
12 Pauline's employability status in the future." (Tr. 571).

13
14
15 There was no medical evidence from a treating or examining physician that Ms. Aldrich
16 was capable of working. One physician, Peter C. Nora, M.D., F.S.C.S., who saw plaintiff for a
17 neurological evaluation on referral from Dr. Olsen, stated on April 11, 2007 that despite her neck
18 and low back pain and morbid obesity ("weighing between 350 and 400 pounds"), plaintiff was
19 "very, very active in terms of physical work around her house." (Tr. 553.) Admittedly, he only
20 saw her on one occasion and spent only 45 minutes with her, and "50 percent was spent
21 counseling and coordinating the patient's care." (Tr. 555.) He did not conduct any functionality
22 tests and did not provide any opinion regarding her employability. He noted a number of
23 problems that would limit her functionality, however, including large disc herniation at the C6-
24 C7 level causing encroachment on the cervical spinal cord and enlarging disc herniation centralized
25 at C5-C6. (Tr. 554.) He anticipated in the "not-too-distant future" that she would warrant neck
26

1 surgery, but was reluctant to recommend this because of her “overall risk profile for anterior
2 cervical surgery.” (Tr. 554.) He suggested considering “Lap-Band or other gastric bypass type
3 procedure,” presumably to address plaintiff’s obesity, because it would make her cervical
4 surgery “more safe.” (Tr. 554.)

5
6 The only physician who offered a medical opinion that plaintiff was capable of working
7 came from a non-examining physician with Disability Determination Service, who reviewed
8 plaintiff’s medical records way back in June of 2005, shortly after plaintiff had filed a social
9 security claim. (See Tr. 391-98.) Robert G. Hodkins, M.D. noted diagnosis of right rotator tear,
10 “A/C jt DJD with spurs,” “moderate C5-6 DDD” (degenerative disc disease), and BMI 60+
11 (Body Mass Index of +60, aka extreme obesity). After filing out an evaluation form, Dr.
12 Hodkins concluded: “Cl[ien]t appers (sic) capable of light-work parameters with some
13 limitations.” (Tr. 398.) No further explanation was provided. Dr. Hodkins made no reference to
14 plaintiff’s fibromyalgia, sleep apnea, or chronic pain syndrome. He did not conduct any
15 examination of plaintiff. Nor has any reviewing or examining physician on behalf of the
16 Administration provided any opinion regarding plaintiff since 2005.

17 18 PROCEDURAL HISTORY

19 Plaintiff filed an application for Social Security Supplemental Income Benefits on April
20 12, 2005 (Tr. 329). The application was denied initially and upon reconsideration (Tr. 298, 302,
21 303). Ms. Aldrich’s hearing was conducted by an Administrative Law Judge on May 3, 2007
22 (Tr. 572-611). An unfavorable ALJ decision was rendered on June 20, 2007 (Tr. 14-25). While
23 the ALJ found that plaintiff had severe impairments at Step 2, the ALJ also found that based on
24 plaintiff’s past relevant work and residual functional capacity, plaintiff could perform work
25 existing in significant numbers in the national economy (Tr. 24, Finding 9).
26

1 Following the ALJ's adverse decision, Ms. Aldrich filed a timely Request for Review
2 with the Social Security's Appeals Council (Tr. 12-13), which denied her Request for Review
3 (Tr. 6-8), leaving the ALJ's decision as the final administrative decision.

4 Plaintiff sought additional review in this court. This court remanded Ms. Aldrich's claim
5 for further consideration (Tr. 635-40). The court found that the ALJ erred in the assessment of
6 Ms. Aldrich's severe impairments (Tr. 639), specifically in failing to include fibromyalgia as a
7 "severe" impairment despite adequate evidence indicating otherwise (*id.*). The court remanded
8 this matter for further proceedings, including a re-evaluation of Ms. Aldrich's residual functional
9 capacity and "Ms. Aldrich's credibility in light of the fibromyalgia impairment" (Tr. 640).
10 Based on this court's order, the Appeals Council vacated the prior unfavorable ALJ decision and
11 then remanded the case for further proceedings (Tr. 641-42).
12

13 The second ALJ hearing was conducted on August 3, 2009 (Tr. 755-83). An unfavorable
14 ALJ decision was rendered on September 14, 2009 (Tr. 623-34). Ms. Aldrich filed a timely
15 statement of exceptions to the unfavorable ALJ decision on March 29, 2010 (Tr. 622). The
16 Appeals Council found no reason to assume jurisdiction and held that the unfavorable ALJ
17 decision was the final decision of the Commissioner after remand by the Court (Tr. 612-14).
18

19 This appeal followed. Plaintiff alleges the following errors:

- 20 1. The ALJ erred in failing to address the plaintiff's obesity.
- 21 2. The ALJ erred in her assessment of plaintiff's fibromyalgia.
- 22 3. The ALJ's determination regarding plaintiff's credibility was not supported by the
23 substantial evidence of record and is contrary to law.
- 24 4. The ALJ's assessment of medical opinion evidence is not supported by the substantial
25 evidence and is contrary to law.
26

1 “The ALJ is responsible for determining credibility, resolving conflicts in medical
 2 testimony, and for resolving ambiguities.” Andrews v. Shalala, 53 F.3d 1035, 1039 (9th Cir.
 3 1995) (*citing* Magallenes, 881 F.2d at 750). However, the Commissioner “may not reject
 4 ‘significant probative evidence’ without explanation.” Flores v. Shalala, 49 F.3d 562, 570-71
 5 (9th Cir. 1995) (*quoting* Vincent v. Heckler, 739 F.2d 1393, 1395 (9th Cir. 1984) (*quoting* Cotter
 6 v. Harris, 642 F.2d 700, 706-07 (3d Cir. 1981))). The “ALJ’s written decision must state reasons
 7 for disregarding [such] evidence.” Flores, 49 F.3d at 571.

8 DISCUSSION

9 1. The ALJ erred in failing to address the plaintiff’s obesity.

10 Plaintiff claims that the ALJ erred by not citing the Social Security Ruling 02-1, which is
 11 the Commissioner’s Policy Interpretation Ruling, to be used in evaluating disability claims
 12 relating to obesity. SSR 02-1p, 67 F.R. 57859, 2002 WL 31026506. The ALJ failed to consider
 13 this ruling at any step in her decision. (See Tr. 626-34.)

14 Although Social Security Rulings do not have the same force and effect as a statute or
 15 regulation, they are binding on ALJ’s and the Administration, generally, in accordance with 20
 16 CFR 402.35(b)(1).

17 This Ruling notes that when considering obesity, the evaluator should determine whether:

- 18 • The individual has a medically determinable impairment
- 19 • The individual’s impairment(s) is severe
- 20 • The individual’s impairment(s) meets or equals the requirements of a listed
 21 impairment in the listing
- 22 • The individual’s impairment(s) prevents him or her from doing past relevant work or
 23 other work that exists in significant numbers in the national economy.

24 67 F.R. at 57861.

1 The ruling further notes that “adjudicators [are] to consider [the] effects [of obesity]
2 when evaluating disability, . . . including when assessing an individual’s residual functional
3 capacity.” Id. at 5860. Courts generally agree that failure of the Administration to give adequate
4 consideration to the effect of a claimant’s obesity in combination with other severe impairments
5 is error. See, e.g., Villano v. Astrue, 556 F.3d 558, 562 (7th Cir. 2009); Hamby v. Astrue, 260 F.
6 App’x 108, 112 (10th Cir. 2008); see also Baker v. Barnhart, 84 F. App’x 10, 14 (10th Cir. 2003).

7
8 Furthermore, failure to follow recommended treatment rarely is used to deny or cease
9 benefits. 67 F.R. at 57864. See McCall v. Bowen, 846 F.2d 1317, 1319 (11th Cir. 1988). The
10 reason is evident from the Ruling itself. “Treatment for obesity is often unsuccessful. Even if
11 treatment results in weight loss at first, weight lost is often regained, despite the efforts of the
12 individual to maintain the loss.” Id. at 57861. “People with extreme obesity, even with
13 treatment, will generally continue to have obesity. Despite short-term progress, most treatments
14 for obesity do not have a high success rate.” Id. at 57863-64. “Generally, physicians
15 recommend surgery when obesity has reached level III (BMI 40 or greater).” Id. at 57864.
16 “Because of the risks and potential side effects of surgery for obesity, we will not find that an
17 individual has failed to follow prescribed treatment for obesity when the prescribed treatment is
18 surgery.” Id.

19
20 A “treating source’s statement that an individual ‘should’ lose weight or has ‘been
21 advised’ to get more exercise is not prescribed treatment.” Id. “Therefore, we will not find
22 failure to follow prescribed treatment unless there is clear evidence that treatment would be
23 successful. The obesity must be expected to improve to the point at which the individual would
24 not meet our definition of disability, considering not only the obesity, but any other
25 impairment(s).” Id. Additionally, the Ruling notes that failure to follow the recommendations
26

1 to lose weight and receive surgery should not be considered if the individual is unable to afford
2 the prescribed treatment. Id.

3 In essence, this Ruling stands for the proposition that obesity may be a lifelong problem
4 and the ability of a person to address it successfully is not determinative. Instead, the ALJ
5 should consider the impact on residual functional capacity caused by obesity in determining
6 whether to award benefits.
7

8 In this case, the ALJ did exactly the opposite. Not only did she fail to consider the
9 impact of plaintiff's obesity and her related impairments when evaluating plaintiff's residual
10 functioning capacity, but she explicitly found that plaintiff's failure to follow her doctors' advice
11 to lose weight and exercise "suggests that her symptoms are not as severe as she alleges." (Tr. at
12 632.)
13

14 Nor is this error harmless. As noted in the Ruling, "[A]n assessment should also be made
15 of the effect obesity has upon the individual's ability to perform routine movement and necessary
16 physical activity within the work environment. Individuals with obesity may have problems with
17 the ability to sustain function over time. . . . [O]ur assessments must consider an individual's
18 maximum remaining ability to do sustained work activities in an ordinary work setting on a
19 regular and continuing basis. A 'regular and continuing basis' means 8 hours a day, for 5 days a
20 week, or an equivalent work schedule. In cases involving obesity, fatigue may affect the
21 individual's physical and mental ability to work activity. This may be particularly true in cases
22 involving sleep apnea." 67 F.R. at 57862-63.
23

24 All of these issues are present in this case, and the ALJ gave short shrift to all of them.
25 No physical assessment was performed. No functional tests were performed. No physical
26 capacities were measured. The ALJ simply picked out several notes raising possible

1 contradictory statements from the medical records and then gave a broad hypothetical question to
2 the vocational expert, whose opinion served as the basis for her decision. (See Tr. 778-80.)

3 This is insufficient. The ALJ “has an independent ‘duty to fully and fairly develop the
4 record.’” Tonapetyan v. Halter, 242 F.3d 1144, 1150 (9th Cir. 2001) (*quoting* Smolen v. Chater,
5 80 F.3d 1273, 1288 (9th Cir. 1996)). The ALJ’s “duty exists even when the claimant is
6 represented by counsel.” Brown v. Heckler, 713 F.2d 441, 443 (9th Cir. 1983) (per curiam)
7 (*citing* Driggins v. Harris, 657 F.2d 187, 188 (8th Cir. 1981)). Nor is the ALJ relieved of this
8 obligation if the records contain ambiguities, such as the case here. The ALJ’s duty to
9 supplement the record is triggered if there is ambiguous evidence or if the record is inadequate to
10 allow for proper evaluation of the evidence. Mayes v. Massanari, 276 F.3d 453, 459-60 (9th Cir.
11 2001); Tonapetyan, 242 F.3d at 1150.
12

13 The case should be reversed and the ALJ should be instructed to evaluate fully and
14 properly plaintiff’s obesity in light of Ruling 02-1p. This would include an updated functional
15 capacity assessment. We do not know what plaintiff is truly capable of doing and without more
16 current information, no substantial evidence supports this determination.
17

18 2. The ALJ erred in her assessment of plaintiff’s fibromyalgia.
19

20 Unlike the original ruling in which the ALJ failed to consider fibromyalgia as a severe
21 impairment (Tr. 638-40), on remand the ALJ specifically found at Step 2 that claimant’s
22 fibromyalgia was a severe impairment (Tr. 629).

23 Nevertheless, plaintiff complains that “the ALJ offered no assessment which functional
24 limitations were caused by which impairments, so there is no basis to determine whether the
25 limitation on walking was based on degenerative disk changes, fibromyalgia or obesity, all found
26 to be severe impairments by the ALJ.”

1 There is nothing that requires the ALJ to differentiate between severe impairments when
2 evaluating residual functional capacity. As noted in SR 02-1P, for instance, a finding of obesity,
3 in combination with other impairments, may have an overlapping impact. “[W]e will consider
4 any functional limitations resulting from the obesity in the RFC assessment in addition to any
5 limitations resulting from any other physical or mental impairments that we identify.” 67 F.R.
6 57863.
7

8 Again, plaintiff’s treating health care providers provided evidence that her impairments
9 made her unemployable. “A treating physician’s medical opinion as to the nature and severity of
10 an individual’s impairment must be given controlling weight if that opinion is well-supported
11 and not inconsistent with other substantial evidence in the case record.” Edlund v. Massanari,
12 253 F.3d 1152, 1157 (9th Cir. 2001) (*citing* SSR 96-2p, 1996 SSR LEXIS 9). The decision must
13 “contain specific reasons for the weight given to the treating source’s medical opinion, supported
14 by the evidence in the case record, and must be sufficiently specific to make clear to any
15 subsequent reviewers the weight the adjudicator gave to the [] opinion.” SSR 96-2p, 1996 SSR
16 LEXIS 9.
17

18 The ALJ must provide “clear and convincing” reasons for rejecting the uncontradicted
19 opinion of either a treating or examining physician or psychologist. Lester v. Chater, 81 F.3d
20 821, 830 (9th Cir. 1995) (*citing* Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991); Pitzer v.
21 Sullivan, 908 F.2d 502, 506 (9th Cir. 1990)); *see also* Edlund v. Massanari, 253 F.3d 1152, 1158-
22 59 (9th Cir. 2001) (“the ALJ erred in failing to meet, either explicitly or implicitly, the standard
23 of clear and convincing reasons required to reject an uncontradicted opinion of an examining
24 psychologist”) (*citing* Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1995)). Even if a treating or
25 examining physician’s opinion is contradicted, that opinion “can only be rejected for specific and
26

1 legitimate reasons that are supported by substantial evidence in the record.” Lester, 81 F.3d at
2 830-31 (*citing* Andrews v. Shalala, 53 F.3d 1035, 1043 (9th Cir. 1995)). In addition, the ALJ
3 must explain why her own interpretations, rather than those of the doctors, are correct. Reddick,
4 157 F.3d at 831 (*citing* Embrey v. Bowen, 849 F.2d 418, 421-22 (9th Cir. 1988)).

5
6 Because the ALJ failed to meet this heavy burden, it is recommended that the case be
7 reversed and the matter remanded for a more thorough review. Although the ALJ noted
8 fibromyalgia as a “severe impairment” (Tr. 629), she failed to provide a clear explanation for her
9 conclusion that plaintiff was employable despite this severe impairment. SSR 96-8p notes that
10 an RFC assessment must include a narrative discussion describing how the evidence supports the
11 conclusion, citing specific medical facts and non medical facts. Instead, in this case, the ALJ
12 incorporated the flawed evaluation performed by the previous ALJ in June of 2007 (Tr. 626,
13 632) and then gave a somewhat disjointed and inconclusive analysis of symptoms related to
14 fibromyalgia. The diagnosis of “fibromyalgia” was not discussed, at all, in this portion of the
15 ALJ’s decision (see Tr. 629-33). In light of this court’s previous decision and the ALJ’s finding
16 of fibromyalgia as a “significant impairment,” this omission is even more troubling.
17

- 18 3. The ALJ’s determination regarding plaintiff’s credibility is not supported by substantial
19 evidence.

20 If the medical evidence in the record is not conclusive, sole responsibility for resolving
21 conflicting testimony and questions of credibility lies with the ALJ. Sample v. Schweiker, 694
22 F.2d 639, 642 (9th Cir. 1999) (*quoting* Waters v. Gardner, 452 F.2d 855, 858 n.7 (9th Cir. 1971)
23 (*citing* Calhoun v. Bailar, 626 F.2d 145, 150 (9th Cir. 1980))). The ALJ also may “draw
24 inferences logically flowing from the evidence.” Sample, 694 F.2d at 642 (*citing* Beane v.
25 Richardson, 457 F.2d 758 (9th Cir. 1972); Wade v. Harris, 509 F. Supp. 19, 20 (N.D. Cal.
26 1980)). An ALJ is not “required to believe every allegation of disabling pain” or other non-

1 exertional impairment. Fair v. Bowen, 885 F.2d 597, 603 (9th Cir. 1989) (*citing* 42 U.S.C. §
2 423(d)(5)(A)). Even if a claimant “has an ailment reasonably expected to produce *some* pain;
3 many medical conditions produce pain not severe enough to preclude gainful employment.”
4 *Fair*, 885 F.2d at 603 (emphasis in original).

5
6 Nevertheless, the ALJ’s credibility determinations “must be supported by specific, cogent
7 reasons.” Reddick v. Chater, 157 F.3d 715, 722 (9th Cir. 1998) (*citing* Andrews v. Shalala, 53
8 F.3d 1035, 1039 (9th Cir. 1995)). If an ALJ discredits a claimant’s subjective symptom
9 testimony, the ALJ must articulate specific reasons for doing so. Greger v. Barnhart, 464 F.3d
10 968, 972 (9th Cir. 2006). In evaluating a claimant’s credibility, the ALJ cannot rely on general
11 findings, but ““must specifically identify what testimony is credible and what evidence
12 undermines the claimant’s complaints.”” *Id.* at 972 (*quoting* Morgan v. Comm’r of Soc. Sec.
13 Admin., 169 F.3d 595, 599 (9th Cir. 1999)); Reddick, 157 F.3d at 722 (citations omitted);
14 Smolen v. Chater, 80 F.3d 1273, 1284 (9th Cir. 1996) (citations omitted). The ALJ may consider
15 “ordinary techniques of credibility evaluation,” including the claimant’s reputation for
16 truthfulness, inconsistencies in testimony, daily activities, and “unexplained or inadequately
17 explained failure to seek treatment or to follow a prescribed course of treatment.” Smolen, 80
18 F.3d at 1284. The decision of the ALJ should “include a discussion of why reported daily
19 activity limitations or restrictions are or are not reasonably consistent with the medical and other
20 evidence.” SSR 95-5p 1995 SSR LEXIS 11. “[I]f a claimant ‘is able to spend a *substantial part*
21 of her day engaged in pursuits involving the performance of physical functions that are
22 transferable to a work setting, a specific finding as to this fact may be sufficient to discredit a
23 claimant’s allegations.”” Vertigan v. Halter, 260 F.3d 1044, 1049 (9th Cir. 2001) (*quoting*
24 Morgan, 169 F.3d at 600).

1 The determination of whether to accept a claimant's testimony regarding subjective
2 symptoms requires a two-step analysis. 20 C.F.R. §§ 404.1529, 416.929; Smolen, 80 F.3d at
3 1281 (*citing* Cotton v. Bowen, 799 F.2d 1403 (9th Cir. 1986)). First, the ALJ must determine
4 whether there is a medically determinable impairment that reasonably could be expected to cause
5 the claimant's symptoms. 20 C.F.R. §§ 404.1529(b), 416.929(b); Smolen, 80 F.3d at 1281-82.
6 Once a claimant produces medical evidence of an underlying impairment, the ALJ may not
7 discredit the claimant's testimony as to the severity of symptoms "based solely on a lack of
8 objective medical evidence to fully corroborate the alleged severity of pain." Bunnell v. Sullivan,
9 947 F.2d 341, 343 (9th Cir. 1991) (*en banc*) (*citing* Cotton, 799 F.2d at 1407). Absent
10 affirmative evidence that the claimant is malingering, the ALJ must provide "clear and
11 convincing" reasons for rejecting the claimant's testimony. Smolen, 80 F.3d at 1283-84;
12 Reddick, 157 F.3d at 722 (*citing* Lester v. Chater, 81 F.3d 821, 834 (9th Cir. 1996); Swenson v.
13 Sullivan, 876 F.2d 683, 687 (9th Cir. 1989)).
14
15

16 As noted above, the ALJ did not perform a sufficient analysis to support her conclusions
17 regarding plaintiff's credibility. The analysis did not articulate specific reasons for her
18 conclusions, such as citing medical evidence that contradicted plaintiff's testimony regarding
19 functional capacity (Tr. 630). Instead, the ALJ chose to discount plaintiff's testimony based in
20 part, at least, on plaintiff's failure to follow the physician's recommendation to lose weight and
21 exercise, considerations that are specifically prohibited by SSR 02-1p. At most, by pointing out
22 some evidence in the medical records that contradict other portions of the medical record, and
23 her testimony, the ALJ only demonstrates why additional evidence must be obtained in order to
24 resolve these conflicts. The ALJ's assessment of the medical evidence is not supported by
25 substantial evidence of record and is contrary to law.
26

1 Because the above analysis is dispositive and somewhat duplicative of the final two basis
 2 of appeal, the court adopts plaintiff's analysis of these issues and concludes that the ALJ's
 3 assessment of medical opinion evidence and Step 5 are not supported by the substantial evidence
 4 and are contrary to law.

5 4. Relief requested.

6 Plaintiff requests that the case be reversed and that benefits be awarded. The Ninth
 7 Circuit has put forth a "test for determining when evidence should be credited and an
 8 immediate award of benefits directed." Harman v. Apfel, 211 F.3d 1172, 1178 (9th Cir.
 9 2000). It is appropriate where:

11 (1) the ALJ has failed to provide legally sufficient reasons for
 12 rejecting such evidence, (2) there are no outstanding issues that must
 13 be resolved before a determination of disability can be made, and (3)
 14 it is clear from the record that the ALJ would be required to find the
 15 claimant disabled were such evidence credited.

16 Harman, 211 F.3d at 1178 (*quoting Smolen v. Chater*, 80 F.3d 1273, 1292 (9th Cir.1996)).

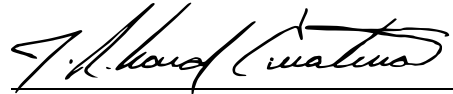
17 Here, outstanding issues must be resolved. See Smolen, 80 F.3d at 1292. There is a large
 18 volume of medical and other evidence and the ALJ must develop the record properly.

19 Therefore, remand is appropriate to allow the Administration the opportunity to consider
 20 properly all of the lay and medical evidence as a whole and to incorporate the properly
 21 considered lay and medical evidence into the consideration of plaintiff's credibility and residual
 22 functional capacity. See Sample, 694 F.2d at 642. Remanding the matter will allow the
 23 administration the opportunity not only to reconsider its decisions at steps three through five of
 24 the sequential disability evaluation, but also to fully consider the evidence plaintiff submitted to
 25 the Appeals Council.
 26

CONCLUSION

Pursuant to 28 U.S.C. § 636(b)(1) and Fed. R. Civ. P. 72(b), the parties shall have fourteen (14) days from service of this Report to file written objections. See also Fed. R. Civ. P. 6. Failure to file objections will result in a waiver of those objections for purposes of de novo review by the district judge. See 28 U.S.C. § 636(b)(1)(C). Accommodating the time limit imposed by Rule 72(b), the clerk is directed to set the matter for consideration on March 4, 2011, as noted in the caption.

Dated this 8th day of February, 2011.


J. Richard Creatura
United States Magistrate Judge